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“A Vital Christian Presence in Social Work”

**THE BIOPSYCHOSOCIAL STRESS OF INFERTILITY:
GRAPPLING WITH THE ETHICAL AND MORAL CONCERNS
VIS-À-VIS ASSISTED REPRODUCTIVE TECHNOLOGIES**

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Introduction

The Webster’s New Universal Unabridged dictionary defines family as “parents and their children” or “persons related by blood or marriage” or “those who descend from one common progenitor”. According to this definition of family, parenthood is an expectation of a couple. Parenthood, especially for married couples is seen as a moral obligation that has its roots in both religious beliefs and cultural norms. Society, community, churches, and family often pressure women to be married and after they are married to bear children. Not only are couples expected to have children, but also they are expected to have children “on time,” usually about 2 to 3 years after marriage (Daly, 1999, p.3).

Among the married population are couples that are members of a small but growing demographic group who do not want children and a significantly large growing demographic group that desire biological children. The reasons for voluntary childless

couples for opting out of parenthood range from religious to ideology to simple lifestyle preferences. Some feel that they do not have what it takes to be good parents. Some are overly committed to their careers or to their hobbies and cannot spare time to raise a family. Others feel that having children would be an intrusion into their marital relationship. Some enjoy the freedom to travel, to make spur-of-the-moment plans, and do not want their lifestyle changed. Some feel choosing not to have children is desirable in order to avoid contributing to the problem of overpopulation (Zastrow & Kirst-Ashman, 2001). Still others are afraid of having a child until they have sufficiently healed themselves from the wounds of childhood traumas (Wickles, 1991). There is also that group of persons who claim that they do not feel a sense of call to parenthood.

On the other hand, the reasons identified for couples desiring biological children range from religion to ideology to economic necessity and cultural expectations. Historically, in agricultural and pre-industrial societies children were an economic asset; their labor was important in planting and harvesting crops and in tending domestic animals. Parents wanted large families to help with the work. When parents became elderly, children tended to provide much of the care. Because children were an economic asset, values were gradually established that it was natural and desirable for married couples to want to have children. Motherhood became invested with a unique emotional aura (Zastrow et al., 2001). Biblically, having children is a blessed event. Infertility constitutes grounds for divorce in many cultures. Long after making the choice not to have children, an older woman may have any number of feelings, including contentment, pride, regret, curiosity, or relief about her choices and how they have affected her life (Wickles, 1991).

More recent research shows reasons for couples desiring children to include (1) children are an extension of the self or a source of personal fulfillment and satisfaction; (2) children enhance their identity; (3) they look forward to the companionship that youngsters will bring; (4) they want to nurture, motivate, and help children become happy and mature; (5) they want to give their children what they themselves never had; and (6) many couples want children because society expects it of them; it is what married people do (Turner et al. 1993).

Regrettably, not all couples desiring biological children are successful in achieving a pregnancy or carry a pregnancy to live birth. This inability to have biological children is called infertility. In North America, the commonly accepted medical definition of infertility is one year of unprotected coitus without conception in non-sterilized couples (Speroff, Glass, & Kase, 1989); the inability to conceive or carry to live birth a pregnancy after one year of regular sexual relations without the use of contraceptives (Turner et al. 1993; Fouad & Fahje, 1989). Within the African context, the term infertility encompasses an inability to conceive, miscarriages, the loss of a fetus between conception and five months of age, and stillbirth (Sewpaul, 1999). The World Health Organization suggests two years as a more realistic time frame to determine infertility.

In the United States more than 1 in 12 couples has difficulty conceiving (Mosher, 1988) and it may be as high as 1 in 7 for couples in their late thirties and early forties (Stovall, Tomah, Hammond, & Talbert, 1991; Cooper-Hilbert, 1998) or over 10 million people are affected by infertility. Approximately 50 percent will never have children of

their own. Researchers have identified a number of explanations for the increased numbers of infertile persons in the United States, which include the following factors:

1) Increased incidence of sexually transmitted diseases such as gonorrhea, chlamydia, and syphilis - These venereal diseases, which damage the reproductive system, are on the rise because of the increased availability of effective birth control measures contributing to a more open approach toward sexual activity. This has led to an increased number of sexual partners for both men and women (Sher, Davis, & Stoess, 1998; Goodwin, 2001).

2) Postponement of parenthood past the age of peak reproductive capability - The longer a woman delays reproduction, the lower are her chances for conception (Rubin, 1984, p. 153). Older women take longer to conceive than those who are younger because some disorders that produce infertility show up in the second half of the woman's life span. These include hormonal problems, endometriosis, and development of benign fibroid tumors. Women 40 or older have a 50 percent fertility rate, and they risk the danger of spontaneous abortion two to three times more than younger women (Toner & Flood, 1993). In addition, the ability to ovulate healthy eggs and concurrently generate a hormonal environment that can adequately support a pregnancy becomes increasingly compromised as a woman gets older (Sher et al., 1998; Collard, 1999; Goodwin, 2001). A man's age also affects fertility to a smaller degree.

3) Increased use of medications and "recreational drugs" - Alcohol, nicotine, marijuana, and other psychotropic drugs can significantly reduce both male and female fertility because they are capable of altering the genetic material of eggs and sperm. Cocaine use also has been found to affect male fertility. Large amounts of cocaine

interfere with luteinizing hormone release, which, in turn, directly affects testosterone levels. Testosterone is necessary for manufacturing sperm, and decreased testosterone levels may lead to decreased sperm production. Cocaine use is responsible for the constriction of arteries. Reduced blood flow to the testes may contribute to the inhibition of sperm production (Zastrow et al, 2005).

Biopsychosocial Model

Infertility is at once a medical, psychological, and social problem. As a result a biopsychosocial model has been employed to address the dynamic relationship between the biological, psychological, and social aspects of infertility. All aspects are crucial in their influence in understanding and treating the infertile couple. The biopsychosocial model may also be used to address the collaborative or multidisciplinary approaches to caring for the infertile couple.

Biological

The biological refers to what infertility does to a person's body, the various medical diagnoses, causes of infertility, and medical interventions. Empirical data provide some estimate of the primary causes, with approximately 35-40 % due to female factors, 35- 40 % due to male factors, 15—20 % due to combined factors, and a residual of 15-10 % for which no explanation can be determined with current technology (Cooper-Hilbert & Hilbert, 1993; Mahlstedt, 1987; Speroff, Glass, Kase, 1989). Specific causes can be determined only by an extensive workup, which typically include many physical examinations, frequent review of basal body temperature, and intercourse records, laboratory tests, radiologic tests, surgery, and trials of medical treatment (Eunpa, 1995).

Causes of Female Infertility

- Adhesion (scar tissue) from previous surgery or pelvic infections
- Antisperm antibodies
- Block fallopian tubes (tubal obstruction)
- Cervical mucus that does not allow the sperm to enter the uterus and fallopian tubes (cervical factors)
- Endometriosis
- Hormonal abnormalities
- Irregular ovulation or failure to release an egg
- Maternal age
- Repetitive miscarriages
- Unexplained infertility
- Uterine lining which is inadequately prepared

Causes of male infertility

- Abnormal sperm motility
- Antisperm antibodies
- Suboptimal sperm or lack of sperm (Cooper-Hilbert, 1998)

Environmental toxins, declining health conditions, medical problems, inappropriate timing of sexual intercourse, stressful lifestyles, personal problems, vocational pressures, general mental health have all been blamed as contributors to infertility in both sexes (Mahlstedt, 1987 ; Allgeier & Allgeier, 2000, Zastrow et al, 2001).

Assisted Reproductive Technology

For the couple having trouble conceiving, their best opportunity for evaluation and treatment lies within the domain of assisted reproductive technologies. Assisted reproductive technologies (ART) or reproductive-aiding technologies are all clinical treatments and laboratory procedures used in the United States since 1981 to help women become pregnant, most commonly through the transfer of fertilized human eggs into a woman's uterus. Since 1981 several new birth technologies have offered hope to those who have experienced the disappointments in their quest for children. These procedures include, in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), and embryo cryopreservation (Turkington & Alper, 2001), male infertility surgery and medical therapy, and Oocyte cryopreservation for cancer patients. Other alternatives may include adoption and surrogate motherhood.

Possible ARTs Risks and Complications

- In vitro fertilization (IVF) takes a physical toll on couples, especially women.
- Fertility drugs, often taken to prepare for ART, have side effects such as hot flashes, abdominal discomfort, and ovarian enlargement. These affect egg donors as well. Ovarian hyper-stimulation, in which the ovaries temporarily become swollen and painfully filled with cysts, may result from multiple injections of gonadotropins, which are used to stimulate egg-containing follicles in the ovaries.
- The rate of pregnancy and birth complications increases greatly with each additional fetus beyond a singleton. Multiples are more likely to be premature

and low-birth-weight – both factors associated with greater infant mortality – and to have extensive stays in the neonatal intensive care unit (NICU).

- Although it is possible to avoid such complications by pregnancy (or fetal) reduction – selectively aborting one or more of the fetuses in a multiple pregnancy – doing so may be religiously objectionable and cause great emotional stress to an individual or couple who have waited so long for pregnancy. An additional risk is the loss of all fetuses.
- Pregnancies conceived through IVF that involve multiple gestations are subject to more risks and involve more medical intervention than those spontaneously conceived.
- Although currently available data is reassuring, it has been hypothesized that repeated treatment with gonado-tropins can lead to an increased risk of ovarian cancer.
- Fifteen years after IVF was first offered, IVF procedures for most infertility diagnosis lack reliable scientific evidence to show that they are effective, that is, that the treatment is more likely to result in a live birth than no treatment. Likewise, variations such as intra-fallopian transfer (GIFT) and Zygote intra-fallopian transfer (ZIFT) have not been proven to be of real benefit, and questions of safety remain unresolved. Despite this lack of evidence, such applications are widespread

Psychological

The psychological aspect addresses behavior and mental processes that involve cognition, emotions, and motivation. The manifestations are observable in how infertile

individuals and couples deal with grief and loss issues, or how they adjust and adapt to involuntary childlessness.

While not all persons experience infertility as a crisis, research indicates that infertility represents a difficult and painful grieving process for the infertile (Seibel & Taymor, 1982). Infertility is not just a medical condition to be treated with fertility drugs, surgery or assisted reproductive technology, but is often a crisis that profoundly affects nearly all aspects of one's personality and life (Zoldbrod, 1998). The primary loss from infertility is obviously that of a biological child. As with any loss, however, this leads to many associated losses, including the lack of a pregnancy experience; loss of a successful pregnancy and birth experience; loss of genetic continuity; loss of one's self-image as a fertile person; loss of the opportunity to move to the next stage in the family cycle; relationship losses; and losses for other family members such as potential grandparents (Conway & Valentine, 1988; Herz, 1984; Menning, 1980).

Infertility is generally viewed as an unanticipated change in life progress and is often experienced as development gone awry (Butler & Koraleski, 1990), a disruption of the marital relationship and roles (Forrest & Gilbert, 1992), a crisis of self-esteem, sexuality, and values (Cook, 1987), a personal failure (Matthews & Matthews, 1986), and an experience of tremendous losses (Burns, 1987; Conway & Valentine, 1988). Other feelings identified with the grieving process include guilt, shame, envy, anger, helplessness or lack of control, sadness, surprise, denial, isolation, anxiety, and depression. (Dunkel-Schetter, 1991; Hertz, 1984; Raphael, 1983; Sawatzky, 1981; Spencer, 1987). Women however, reportedly experience greater psychosocial distress,

more somatic difficulties, lower self-esteem, higher levels of depression, and greater interpersonal sensitivity related to their infertility (Elliott, 1998).

The Stigma of Infertility

Miall's (1985, 1986) study referred to three major societal attitudes, which women felt supported the idea that society views infertility as a discreditable attribute: the belief that infertility stems from psychological conflicts; "the association of infertility with sexual incompetence" (Greil, 1991, p. 126); and the assumption that if a couple is infertile, it is the woman's fault. According to Miall (1985, 1986), infertile women feel stigmatized as a result of self-labeling". She defines self-labeling as "the perception of stigma by hidden or secret deviants" (Miall, 1986, p.279), and notes that this results from the realization that others will view a given attribute as discreditable if they learn of it.

Jan Rehner (1989) reflecting on her own experience, points out that "when the ability to bear a child is denied a woman, no matter how intelligent, how independent, or how unconventional, she must reexamine what it means to be a woman-not in an impersonal or theoretical way but in terms that strike at the very heart of [her] self-image." Because the ability to generate life (or to impregnate) is widely viewed as a "flowering" of sexual capacity, infertility cuts at core assumptions about one's adult sexuality. It is therefore, an assault on self-concept for those to whom fertility has become important. The sense of failure "spills over" into other aspects of life (Ryan, 1993).

The following are excerpts from interviews lifted from previous study that powerfully illustrate the reality of the lived experience of infertility:

When I discovered I was infertile, I felt damaged. Why couldn't I accomplish something as "natural" as conceiving a baby? Suddenly my

sense of self-worth was shaken. I felt defective and very much a failure. Infertility was more than a medical problem. It was an attack on my self-esteem (Mahlstedt, 1985, p. 338).

Not only is there the experience of grave emotional pain and a sense of being a failure, but a loss that results in a person's sense of worth:

My infertility is a blow to my self-esteem, a violation of my privacy, an assault on my sexuality, a final exam on my ability to cope, an affront to my sense of justice, a painful reminder that nothing can be taken for granted. My infertility is a break in the continuity of life. It is, above all, a wound to my body, to my psyche, to my soul (Mahlstedt, 1985, p. 345).

And it's not just the fear that the dream of being parents may not be realized, but the future of the marriage is being jeopardized by infertility. One man said:

One of the reasons I married my wife was because I knew she'd be a good mother and I'd be a good father. So now if we're married and she's not going to be a mother and I'm not going to be a father, what the sense of being married? (Daniluk, 2001, p. 5).

To be faced with bodies which betray them, or natural forces, which refuse to cooperate, are for many an experience of powerlessness for which they have not yet been prepared (Ryan, 1993). Involuntary childlessness often leads persons to question the authenticity of their family unit and creates a crisis of self as expressed by a husband:

Being a parent and having a family was always a part of the picture for us. We are going to be parents. That's part of how I understood my wife and myself. And now, it may not happen. I'm a husband but I'm not a father. So who am I now, and who is my wife, and are we really a family—can we be, without kids? (Daniluk, 2001, p. 5).

Marital Effects of Infertility

Many couples marry or make a commitment to one another with the implicit or explicit understanding that they will have children and raise a family. For many couples, having a baby is part of a larger life plan to bring a child into their lives, create a family, carry on bloodline, or strengthen a relationship. For most, this happens relatively routinely and they do not have to question or examine their relationship as it relates to their capacity to bear a child and raise a family. For couples suffering from infertility, however, the situation is different (Goodwin, 2001). According to Stanton et al (1991) couples reactions to infertility vary considerably. However, research data overwhelmingly show the deleterious effects of infertility on marital relations.

In one of the earliest studies that examined psychological problems among infertile patients, Bell (1981) studied ten couples presenting at an infertility clinic for the first time and ten couples already undergoing treatment. Seven of the 20 couples reported deterioration in the marital relationship, leading the author to conclude that there is likely to be a large incidence of marital dissatisfaction in this population and noting the need for continued longitudinal research (cited in Goodwin, 2001, p. 34-35).

Mahlstedt (1985), in a later study, examined the impact of infertility on relationships from the perspective of coping styles. She argued that each member of the couple may be impacted differently. While the intensity of the despair may not be different, the individuals simply may have different coping strategies. For example, men often cope with their pain by keeping it to themselves and focusing on their wives. Women often cope by talking continually about their pain with their husband who, feeling powerless to take away the pain, sometimes stops listening. The wife escalates her

complaints, while the husband withdraws further, and the cycle of resentment and depression keeps going. The end result is that they are not just coping dysfunctionally with their infertility, but the closeness in their relationship is being jeopardized. A spouse may begin to feel resentment and rage toward his or her partner (Atwood & Dobkins, 1992) or fear that ‘they’re the one’ responsible for the infertility (Cooper-Hilbert, 2001). If one partner places the blame of infertility on him-or-herself, there is an increase in distress for that partner (McEwan et al. 1987). Vieyra et al (1990), commenting on the tendency of women to blame themselves for infertility even when the cause of the infertility was located in their husbands, state that women may take on the responsibility for the infertility in order to protect their husbands from having to acknowledge a deficit in their masculinity (cited in Darsney, 1996, p 35).

Problems with infertility can have profoundly negative effects on a couple’s relationship and sexual functioning. Partners may also become isolated from each other and believe that the other does not understand. Each feels inadequate about his or her masculinity or femininity due to problems with conceiving. Each may feel anger and guilt and wonder, “why me?” Both may feel grief over life experiences they can never have: namely pregnancy, birth, and conceiving and rearing their own biological children. Intercourse itself may evoke these uncomfortable feelings and become an emotionally painful, rather than pleasurable, and the couple experience fraught with anxiety about failing to conceive (Cooper-Hilbert, 1999).

While assisted reproductive technology offers couples an opportunity to achieve a pregnancy when other measures have failed, they sometimes serve a source of stress. During the infertility treatment, some procedures such as post coital test can increase

feelings of anxiety. Stress also seems to have a worsening effect on the quality of collected semen (Tarbusi, Mattea, Valpe & Facchinetti, 2000).

A common observation from infertile couples is that assisted reproductive technology takes away a couple's privacy and sense of control. One couple sums up their experience with these words:

First came a simple blood test that measured hormone levels at certain points in my cycle. The next test gauges compatibility-a post coital test to look at how my husband's sperm survived in my cervical mucus. The test was timed during ovulation and within two hours of intercourse. I remember my husband's embarrassment when he learned how much I shared with my doctor.

Burns (1995) laments the fact that with the increase technology in infertility treatment, male and female patients are becoming to feel more like technicians and their bodies instruments. Intercourse scheduled around ovulation, sperm specimens being collected for evaluation, and postcoital exams can darken a bedroom, diminish pleasure and playfulness, and even alter the meaning of sexuality and lovemaking (p. 26).

Social

The social component of infertility must be examined within the social structures and social organizations like the family and the community. In the family girls are taught that motherhood is the ultimate expression of femininity. From a more communal perspective, families ensure that dying and aging members of society will be replaced in an orderly fashion so there is new generation. For infertile individuals and couples, there are societal constraints and messages that direct how they deal with childlessness.

Women more than men who are infertile tend to ask themselves who they are if they cannot become parents. Infertility is no longer a medical condition but a definition of self (Devereaux & Hammerman, 1998). As their infertility become more undeniable, they

may feel a great sense of isolation from others during social discussions of pregnancy, childbirth, and childrearing (Diamond et al., & Schulman, 2000). As one woman who has been unable to conceive stated:

Coffee breaks at work are the worst times; everyone brings out their picture of their kids and discusses their latest parental trials and tribulations. When one of the women complains about having problems with something like a child, I just want to shout at her and tell her how lucky she is to have a problem (Crooks & Baur, 2002, p. 332).

Unfortunately, unlike abortion issues, which are fairly well crystallized and articulated, the issues and institutional values concerning infertility and reproductive technologies are only now being discovered and defined (Zastrow et al. 2001).

Ethical and moral concerns vis-à-vis Assisted Reproductive Technologies

Assisted reproductive technologies challenge some of our most entrenched moral and cultural traditions; included are some basic assumptions concerning conception, responsible procreation, and what is it to be a mother and a father. The irony is that, on one hand reproductive technologies offer hope where previously none existed, while on the other hand introduced a series of complex, expensive, and often morally troubling treatment modalities.

The range of ethical dilemmas that has been raised in particular about in-vitro fertilization and embryo transfer (and others) are shown by the following classifications: dilemmas originating in our taboos about sexuality; dilemmas associated with conflicts of interest among participants in the reproductive process, such as the donor of the gametes, the surrogate women in whose uterus the fetus develops, and the fetus itself; dilemmas pertaining to the moral status of the embryo/fetus; dilemmas stemming from moral

concern about the nature of mankind and whether we should interfere with natural reproductive processes; and dilemmas relating to the resolution of moral conflicts that arise among individual member of a pluralistic society who hold different views on these issues (Biggers, 1990, p.552).

The following are some concerns that illuminate some of ARTs unresolved issues:

- With respect to ART involving sperm donation, some authorities have been concerned that the child who results might eventually marry a close genetic relative. Orthodox Judaism forbids this practice and suggested the use of donor sperm is “quasi-adulterous.”
- Some Orthodox authorities find a child born without a relationship to or even knowledge of his genetic parents innately objectionable. Others worry that being the product of a donated gamete will affect the child’s sense of identity and that asymmetry in the child-parent relationship will affect that relationship and strain the marriage.
- Perhaps the most spectacular of the assisted reproductive technologies is the human in-vitro fertilization and embryo transfer (IVF-ET), first reported by Steptoes and Edward in 1978. From its inception this technique has raised debates about the ethical aspects of reproductive technologies and in 1987 the Vatican formally denounced them as amoral (Biggers, 1990).
- Inequalities of access mask social judgments about who is fit to reproduce (Ryan, 2001, p. 33). The demographics of infertility reveal that some of the medical and

social causes of infertility disproportionately affect poor women and women of color. This fact, combined with the recognition that infertility separates the infertile from important relationships and goals that help shape self-identity, leads Ryan to argue that a concern for justice may require us to acknowledge a right to assisted reproduction (Lauritzen, 2002).

- Most fertility enhancing techniques are expensive. They may be available, but not accessible to poor people and the uninsured. Fertility clinics and other medical centers that provide ART services will only treat those who can pay for the services.
- The costs of ART services are extremely high while there is a relatively poor success rate.
- Radical feminism disparages the techniques as “reproductive abuse,” a product of the “spermatic economy of sex and breeding” or “spermocracy,” and “medicalized pornography”. Within the radical feminist ideological belief system, anything developed within the ‘patriarchy’...the “seamless web of male oppression” must be condemned, regardless of the apparent benefit to women (McElroy, 1994).

The resolution to the above stated problems may or may not be in the near future. It is not as if infertility clinics are completely on their own. Federal law requires IVF programs to report success rates and other statistics to the Centers for Disease Control and Prevention (CDC), which publishes that data annually. The Federal Trade Commission has issued cease-and-desist orders to several IVF Clinics whose advertisements misrepresented clinic success rates. The Food and Drug Administration

(FDA) is establishing rules requiring sperm banks and infertility clinics to screen sperm, egg, and embryo donors to prevent transmission of communicable diseases. Some states have laws or regulations addressing donor screening, record-keeping, information disclosure, and parental rights (Dresser, 2000). Also a few states have mandatory certification and licensing requirements covering different aspects of ART (Daar, 1997).

According to U.S. Senator Hayden, the following distinct features of infertility treatment leave it less constrained than other medical practices. First, because the FDA approval process that governs drugs and other medical products does not cover novel ART procedures, ART procedures need not meet FDA safety and efficacy standards before entering the clinical arena. Second, the National Institute of Health and other federal agencies rarely support research relevant to ART; therefore, innovative approaches may be tried in the clinical setting without prior research ethics review. Third, because insurance coverage for ART is quite limited, reimbursement requirements fail to promote quality care. Fourth, because ART interventions may be performed outside hospital settings, hospitals are not able to screen out unqualified practitioners. Fifth, the malpractice system's ability to stimulate quality care is weakened by difficulties in proving negligence, causation, and harm on behalf of patients who fail to have children or have children with health problems (Dresser, 2000, p.1).

The President's Council on Bioethics recent report, *Reproduction and Responsibility* acknowledges and explains the complexity in the context of the United States legal landscape. In doing so, it concludes that the U.S. regulatory framework lacks coherence and that much within it is unenforceable. The Council argues that more needs

to be done to protect consumers, particularly women who receive ART and children born with its help (Thomas, 2004).

In 1983 the English government appointed a committee under the Chairmanship of Baroness Warnock to study Human Fertilization and Embryology. The Church of England (Episcopalian) in their 1985 Synod debated the report of Warnock's Committee and the following motion was carried:

That there should be a national licensing authority to regulate and to control fertility services, and that such an authority should continue to debate on the moral aspects of technologies concerned with human embryology and fertilization, and to this end membership of the authority should include representatives from the social work and legal professions and from members of the churches skilled in moral theology.

Using the biopsychosocial framework to explain the problem, this writer also suggests that the solutions to the problems are to be placed within this framework. The challenges and the solution responses to infertility comprise a simultaneous and an interactive series of exchanges. This framework shows how multidisciplinary perspectives, like medicine, theology, law, and social work (as recommended by the Church of England) can be integrated into collaborative efforts to respond effectively to infertility issues. The importance of understanding infertility and its resolution is clarified by the discussion of the all relevant components within the biopsychosocial framework.

Implications for Social Work Intervention

Social work intervention involves the formation of pressure groups to encourage more public education, extensive research into the causes and treatment of infertility and to alter the traditional manner in which fertility treatment is handled in the medical area. Public education and advocacy must be a strategy to change the medical model that view infertility solely as a medical problem to be solved, a dysfunction that needs to be fixed, and society's view that support this medical view. Society needs to be aware of the immense impact of the crisis of infertility. People in crisis are generally more vulnerable, more suggestible, and more easily manipulated than they are during more normal times. Infertile women in particular need to be and feel empowered, and have their choices maximized (Zastrow, 2001).

While the treatment of infertility falls in the domain of medicine, there are some clinical implications. According to Sewpaul (1995), historically, social work with infertile couples began with adoption. The child was seen as the client, and the counseling focused on the couple's ability to parent. Little recognition was given to the infertile couple's need for psychosocial support. Mernning (1975) pointed out that there were large cracks that existed between gynecologist's room and the social worker. Infertile persons are expected to heal themselves and to present to the adoption worker with resolution of infertility and a readiness for adoption. The reality is that some couples need clinical help to resolve their grief and loss issues. Freud (1917), Bowlby (1980), Lindemann (1949), Parkes (1972), and Raphael (1983) have all contributed important theoretical and research work about grief and its resolution. The relevant literature makes a convincing case for the social work clinician to become knowledgeable about infertility

issues with a view to helping the infertile persons on their caseloads work through their unresolved psychosocial and psychological issues.

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